



Kansas Department of Corrections Services to the Mentally Ill

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Fact

The Kansas Department of Corrections is the largest provider of mental health services in the state of Kansas.

CHARACTERISTICS OF POPULATION

Mental Illness

Alcohol and Drug Addiction

Homeless

Intellectual/Development Disabilities

Traumatic Brain Injury

Physical Health Problems

Limited Education

Limited Family Support

Poor Work History

Fetal Alcohol Syndrome

Statistics About KDOC Population (as of 8-25-13)

Inmate Population

	Population	Capacity
Male	8852	8799
Female	755	795
TOTAL	9607	9594

Parole Population

Male	4835
Female	703
TOTAL	5538

Juvenile Population

KJCC	201
LJCF	127
TOTAL	328

(below figures as of 7-31-13)

Total in Custody	1394
Total at PRTF	25

(Psychiatric Residential Treatment Facility)

Who is getting sent back to Prison? (2008 Releases)

- Males – 31.1% vs. Females – 20.3%
- High risk offenders - 39%
- Moderate risk offenders – 28.4%
- Low risk offenders – 15.8%
- Sex offenders – 41.8% overall – 38.4% for conditional violations & 3.5% for new offenses
- Mental health level (4-7) offenders – 35.8%

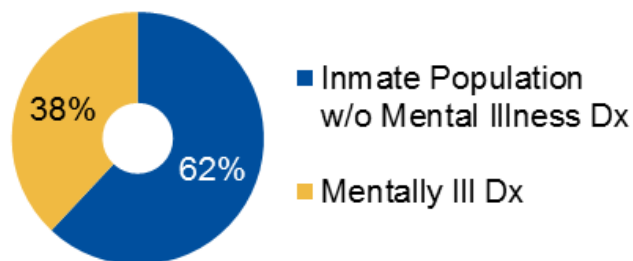
Mentally Ill

Since 2006, the mentally ill population has increased by 126%.

An additional 118 specialized beds will be needed by FY 2015.

Additional staffing cost for mental health intervention through FY 2018 is \$2,085,185.

Mentally Ill Inmate Population

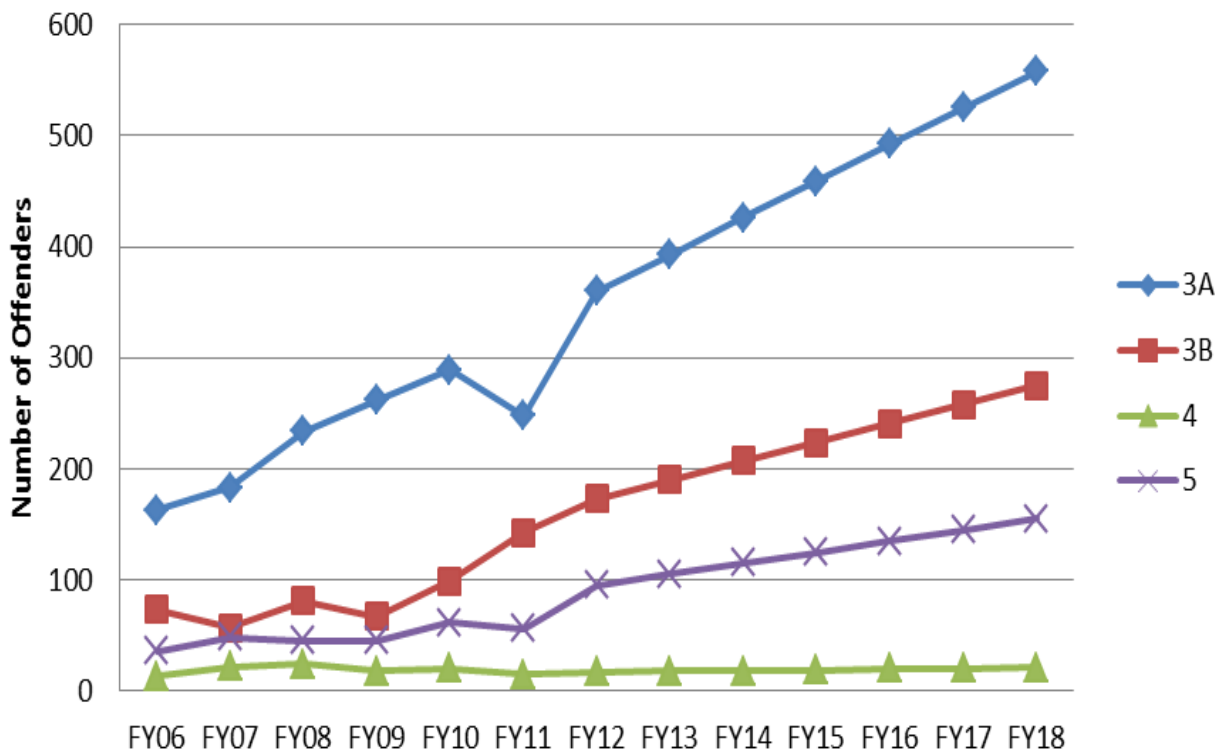


Mental Health (MH) Beds



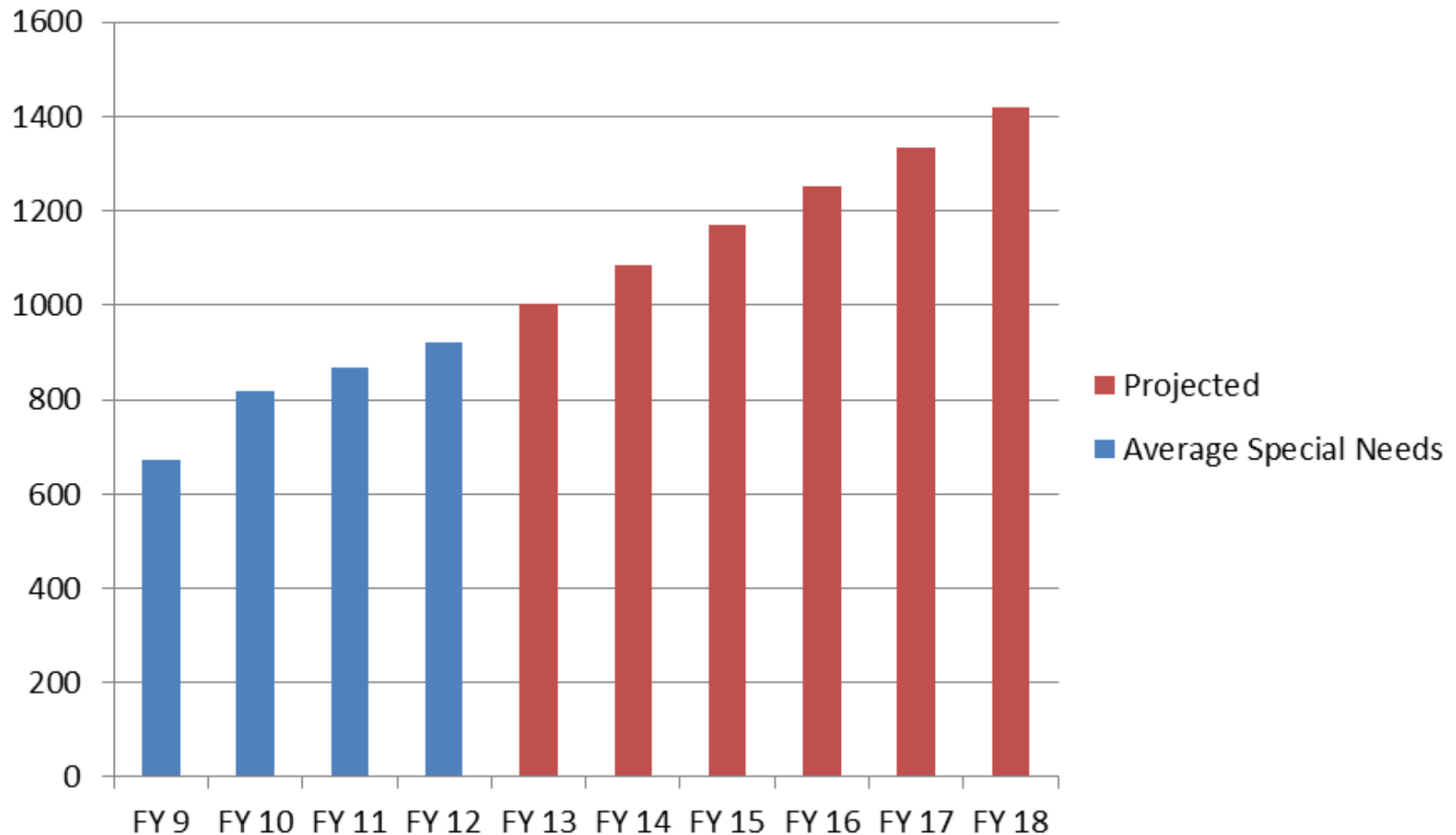
Mentally Ill Offenders in the Facilities

Mental Health Housing Classification Levels



- 3A – Offenders with mental illness who have shown symptoms within the past 6 months.
- 3B – Offenders with symptoms of a major mood disorder or who are marginally stable.
- 4 – Requires a single-cell due to mental disorder.
- 5 – Requires placement in a specialized mental health unit.

Numbers of offenders requiring consistent mental health follow up due to their serious mental illness



Incarcerated Adult Offenders Prescribed Medications

Average Offenders - Psych Meds

FY 09

1,558

FY 10

1,666

FY 11

1,704

FY 12

1,741

Most Probationers Revoked to Prison Have Behavioral Health Needs

Of FY 2011 Probation Revocations

- ✓ ***58% had Substance Abuse score of 4 or higher***
- ✓ ***17% had Mental Health score of 3 or higher***
- ✓ ***12% had both***

For comparison, only 16% of the successfully terminated CC probationers had an SA score of 4 or higher.

- SA Scores range from 0 to 9 and are based on nine questions within the substance abuse domain within the LSI-R risk assessment.
(A score of 4 means that four of the nine questions were answered in the affirmative.)

- MH Scores range from 1 to 7 and are based on a continuum of MH programming intensity.
 1. *Not currently requiring MH*
 2. *Receives time-limited mental health services*
 3. *Receives on-going mental health services that may include medication management*
 4. *Receives special needs treatment monitoring*
 5. *Placed in mental health structured reintegration program at LCF-TRU*
 6. *Placed in intensive mental health placement at LCMHF or TCF-MHU*
 7. *Hospitalization at LSSH*

Successful Probationers Are Twice as Likely to Receive Programming as Those Revoked

**FY 2011
Total CC
Terminations
4,881**

Of successful mod/high risk terminations:

- ✓ 57% completed two or more behavioral health programming interventions.



Of the mod/high risk revocations:

- ✓ Only 31% completed two or more behavioral health programming interventions.

Understanding the Overall Need for Behavioral Health Interventions

- **Key programmatic cornerstone is to utilize cognitive thinking skills interventions**
- **75% of all inmates are moderate or high risk in education and employment**
- **66% abuse drugs and alcohol**
- **33% have a dependence/abuse diagnosis**
- **66% of revocations on parole are largely driven by drug or alcohol abuse**
- **38% of the population is mentally ill**

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**SO HOW DOES KDOC
ATTEMPT TO SERVE THE
MENTALLY ILL POPULATION?**

Behavioral Health Services while Incarcerated

KDOC's comprehensive contract requires at a minimum the following mental health on-site services:

- 1. Psychological evaluation (Reception & Diagnostic Unit)**
- 2. Individual psychotherapy**
- 3. Group psychotherapy**
- 4. Activity & Recreational therapy**
- 5. Case consultation**
- 6. Psychotropic medication**
- 7. Segregation monitoring and review**
- 8. Transfer screening and hearings for higher level of services**
- 9. Crisis intervention – Suicide prevention**
- 11. Discharge Planning**
- 12. Clinical Service Report (follow up psychological evaluations)**

Behavioral Health Services while Incarcerated

1. Use of an Evidence-Based practice model for correctional behavioral health purposes:

- Applying the well-known risk, needs, and responsivity principles to clinical practices.
- Use the philosophy of harm reduction/public safety & recidivism prevention.
- Use of a strength-based assessment and using interventions to decrease symptoms.
- At its core, correctional treatment involves collaboration between treatment and corrections staff.

Behavioral Health Services while Incarcerated

2) Correctional behavioral health treatment that addresses both the behavioral healthcare condition as well as the criminality.

- *Cognitive-Behavioral Treatment:*

Addresses irrational thoughts and beliefs that lead to anti-social behavior.

Behavioral Health Services while Incarcerated

3) Behavioral health interventions addressing:

- Mental Illness recovery - Stress Risk management
- Emotions Management - Skills training
- Institutional Functioning
- Medication adherence
- Trauma risk treatment
- Addiction risk treatment (dual diagnosis)
- Social skills risks
- Re-Entry Needs; and
- Risk- Needs

Behavioral Health Services while Incarcerated

When transfer to a higher level of service is indicated, the contractor has the following options:

- 1. Treatment and Reintegration Unit (TRU) at Lansing Correctional Facility**
- 2. Larned Correctional Mental Health Facility**
- 3. Topeka Correctional Facility Mental Health Pod (female population)**
- 4. Larned State Hospital**

Correctional Facility MH Beds

Current specialized mental health beds

- 108 beds = LSH (De-stabilized & Non-aggressive offenders with mental illness)
 - 120 beds = LCF TRU (Cognitively disabled; stable residential; transitional)
 - 150 beds = LCMHF (De-stabilized or Assaultive offenders with mental illness; residential)
 - 14 beds = TCF (females) Mental Health Pod
- 382 beds = Total

Correctional Facility MH Beds

Additional placements for offenders with mental illness within KDOC:

- 20 beds = EDCF single-celled offenders due to a mental disorder (incl. RDU)
 - 40 beds = LCF/HCF single-celled offenders due to a mental disorder
 - 15 beds = TCF (females) GP offenders
- 75 beds = Total

Strategies Specifically with the SPMI Population - Release

- Discharge planners
- Boundary spanners at community mental health centers
- Strong partnerships with community providers (i.e. Liaisons CMHC's)
- Pre-release benefits applications
- Specialized parole officers (4 in the state)
- Enhanced medication at release under health care contract (30 days + another 15 in prescriptions if needed)

Long-Term Admin Segregation

- Multi-disciplinary teams address behaviors
- In-cell/ Out-of-cell/ programs / treatment
- Targeted cognitive interventions – skills building

Multi-Disciplinary Teams

- **Used for high risk & special needs offenders**
- **For severely mentally ill/dually-diagnosed**
(substance abuse, intellectually/developmentally disabled or behaviorally disordered)

Multi-Disciplinary Teams

Center piece of team's work is stable, permanent, supportive housing & stabilizing behavior

- **Teams include:**

- Facility case manager (unit team counselor)
- Specialized staff (discharge planner, housing specialist, cognitive specialist, job specialist, substance use disorder & mental health treatment)
- Community case manager (parole officer)
- Mentor/family/support and Offender

Discharge Planning

Discharge planning (six of eight facilities)

- Benefits applications
 - Some KDOC staff are SOAR trained and some help with this through CMHCs with liaisons
 - Still lots of challenges in getting benefits in place
 - Partnership with KDHE may lead to more pre-release determinations of eligibility and/or suspending, not terminating during incarceration
- Contact with community mental health centers to set up appointments

New Recourses in the Facility

New (through SCA grant): Four Mental Health Case Managers (2 Lansing, 1 Larned, 1 El Dorado), with specialized caseloads,

- 18 months from release;
- In addition to case management, delivering *Thinking for a Change*. (Note: Recent research reflects: a] two-thirds of OMIs are high risk in anti-social/criminal thinking; b] recidivism will not be reduced with this population using only quality mental health care, though it's necessary.)

New Recourses in the Facility

New (through new program dollars): Peer Support Coordinators at Topeka (women) and Larned (men) for the SPMI offenders.

- Implementing recovery strategies
- Applied for SAMHSA grants in March and April 2013 to provide recovery services for probationers in SG and WY counties and parolees in SH and JO counties, for behavioral disorders, *and* to train 20 staff/volunteers per year in peer specialist/recovery (through KDADS intense training/certification program) to work with offenders with mental illness.

Back to the community

Release planning now includes planning for a placement based on assessments done in the community pre revocation.

Will release with 30 days of meds

Partners on stand by to launch appropriate services pre release

Transparency in the referral process is critical to public safety

Community Support

Liaisons in the community mental health centers in four counties (WY, SN, SG, Saline).

Specialized parole officers (Wichita, Topeka, Kansas City) (offenders who got discharge planning and a specialized parole officer recidivated at 12% compared to 39% [down from 74%] per a Council of State Governments study of 03/04 releases vs. 06/07 releases of offenders with mental illness).

Supportive Housing Programs

Supportive housing programs in WY and SN counties (with care coordination, linkages to treatment and housing support, leading to permanent housing; this program to date has served 24 very high-risk/needs offenders, with a 25% recidivism rate).

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**SUCCESSES KDOC HAS
FOUND IN SERVING THE
MENTALLY ILL POPULATION**

SPMI Results

(Study by Council of State Governments)

**Recidivism rates for offenders with mental illness decreased substantially between
FY03/04 & FY06/07**

❖ FY03/04 rates: 51-74%

❖ FY06/07 rates: 12-39%

❖ **Total Decrease 35-39%**

NOTE: Range is based on level of mental illness (severe/persistent or serious) & services received (only discharge planning, only specialized parole officer, or both, for best results)

No Returns Rates of Offenders Released from KDOC Facilities During CYs 2008-2011

Mental Health Levels 4 to 6 Recidivism: Measurement is Based on 12 Month Calendar Year

	CY 2008		CY 2009		CY 2010		CY 2011	
	Ave Raw	Ave Ratio	Ave Raw	Ave Ratio	Ave Raw	Ave Ratio	Ave Raw	Ave Ratio
No Returns								
Mental Hlth Lvl 4	192	44.24%	190	46.00%	190	45.45%	251	55.04%
Mental Hlth Lvl 5	25	5.76%	17	4.12%	31	7.42%	32	7.02%
Mental Hlth Lvl 6	37	8.53%	40	9.69%	41	9.81%	44	9.65%
Total No Returns	254	58.53%	247	59.81%	262	62.68%	327	71.71%
Returns/Recidivism	180	41.47%	166	40.19%	156	37.32%	129	28.29%
Total (All Releases)	434	100.00%	413	100.00%	418	100.00%	456	100.00%

Note. No Returns is based on Total Releases minus (the sum of Re-Admissions in CY08 to (CY13 Jan to June))

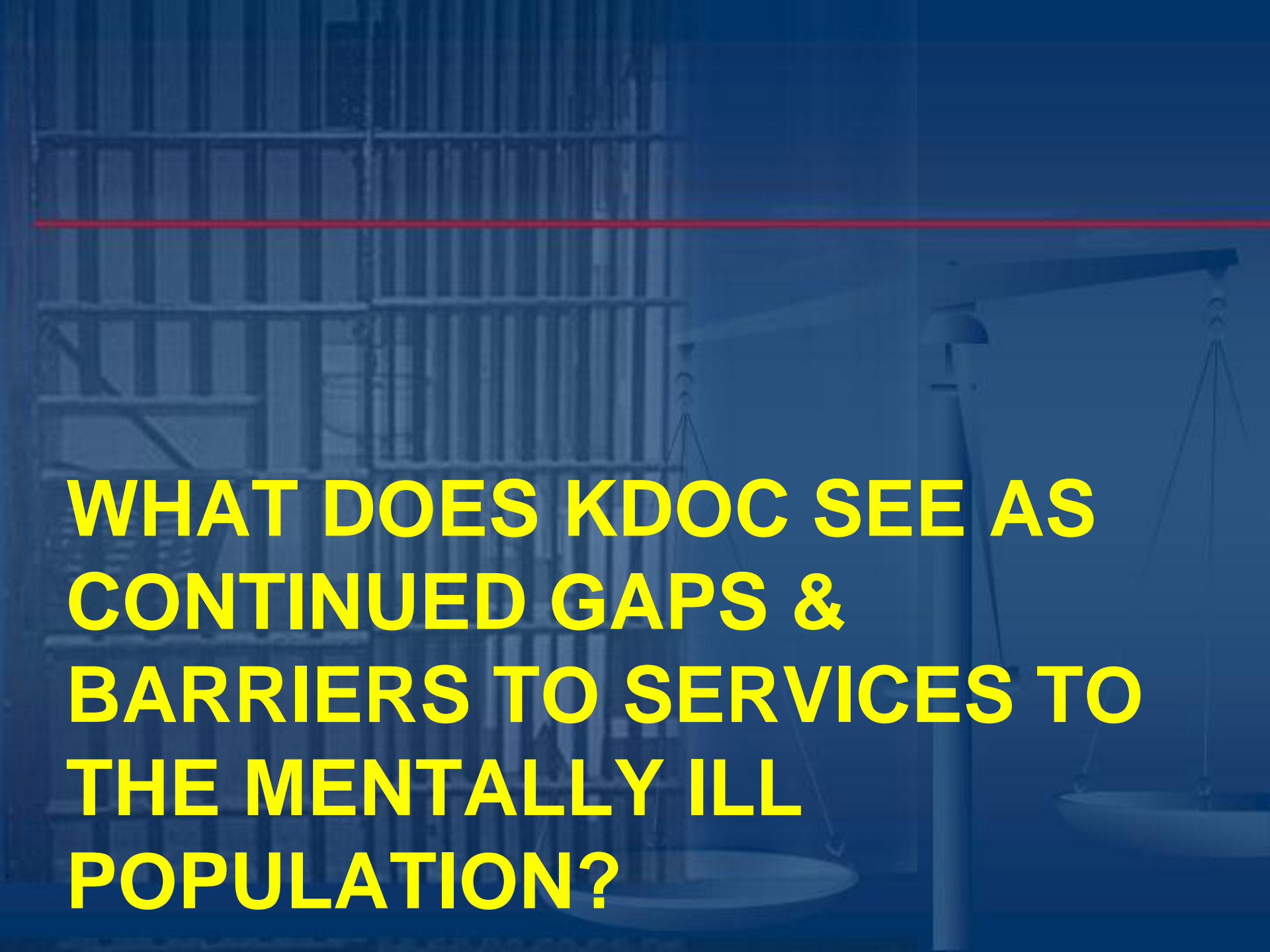
Ave Raw Data shown are data of total offenders who did not return to a KDOC prison facility after the released calendar year

Data Source: Data is from OMIS system and is based on Released Years: 2008, 2009, 2010, & 2011

Benefits/Cost of MDT

Sample Case: Inmate George

- Incarcerated for 18 years
 - Worked with multi-discipline team pre-and-post-release
 - Tracked down use/costs of services 2 yrs before prison (1991-1993) (homeless shelter, ER visits, state hospital, MH/SA treatment, etc.): \$152,000 (not today's costs)
 - Cost of 18 years of prison (\$25,000/yr): \$450,000
 - Cost to taxpayers for 20 yrs., \$602,000, or \$30,100 per yr
 - After being out one year, cost to taxpayers:
 - **Housing stipend: \$975, MH treatment: \$3940, Food stamps: \$1200, Social Security Benefits: \$2020**
- TOTAL: \$8,137 vs. \$30,100 = 73% less**

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**WHAT DOES KDOC SEE AS
CONTINUED GAPS &
BARRIERS TO SERVICES TO
THE MENTALLY ILL
POPULATION?**

Correctional Facilities

- Access to Community Resources at Discharge
- Medicaid Suspension & Termination Issues
- SMI/SPMI Gap – Those with serious mental illness may not be eligible for services, but may destabilize without services.

Correctional Facilities (cont.)

- There will be an additional 118 specialized mental health beds needed by FY15 for incarcerated offenders. Between FY 15 and FY 18 there will be an additional 45 mental health beds needed (Total 163 specialized mental health beds).
- Currently, 5% (457 offenders) of the total population is placed in a specialized mental health bed or specialized placement within the general population.

Community & Field Services

- Have difficulty accessing services for the uninsured. Cost of co-pays are cost prohibitive for offenders that do not have disability.
- 30 days supply of medication at release is often not enough to transition to community based services.
- SMI/SPMI Gap
- Lack of transitional and long term housing.

Community & Field Services

- Lack of transitional and long term housing.
- Transportation to services
- Inability to set up services pre-release with many CMHC's.
- Need for more Specialized PO's in other communities

Children & Youth

- Judges think they can get more services if youth are in CLNC or JO custody. This is not necessarily the case.
- Access to services for transitional aged youth that are aging out of the system. Many youth are transitioning into homelessness.

Children & Youth

- **Lack of resources & care coordination for youth. Juvenile services relies completely on the CMHC's to provide services to their youth placed in the communities.**
- **CMHC's do not always provide access that is needed (i.e. types of services and adequate dosage) or timely access to them. Sometimes won't serve certain populations (i.e. sex offenders)**
- **CMHC's appear heavily invested in traditional therapies (i.e. individual, group, etc.) that may work with general populations, but are not effective for others (ex. offending populations).**

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Questions??